



Provider Nomination Form

Please note: All Providers nominated must meet OCM's contracting criteria and eligibility requirements to receive an application to the network. One Call Medical may not be developing a particular market at the time of your nomination. However, your input is valuable and your nomination will be kept on file for future use.

Fax completed forms to 973-257-9512

| YOUR INFORMATION | |
|--|--|
| First Name: | _____ |
| Last Name: | _____ |
| Company Name: | _____ |
| Phone: | _____ |
| Fax: | _____ |
| Email Address: | _____ |
| PROVIDER INFORMATION | |
| Type of Provider: | <input type="checkbox"/> Neurodiagnostic (EMG/NCS) <input type="checkbox"/> Radiology (MRI/CT) |
| <i>For Neurodiagnostic Providers:</i> | |
| Physician Name: | _____ |
| <i>For Radiology Providers:</i> | |
| Facility Name: | _____ |
| Address 1: | _____ |
| Address 2: | _____ |
| City: | _____ |
| State: | _____ Zip: _____ |
| Phone: | _____ Fax: _____ |
| COMMENTS | |
| | |